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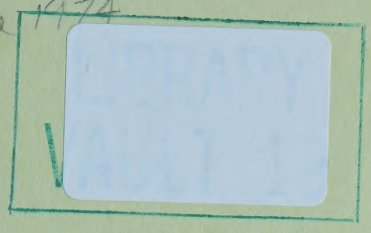

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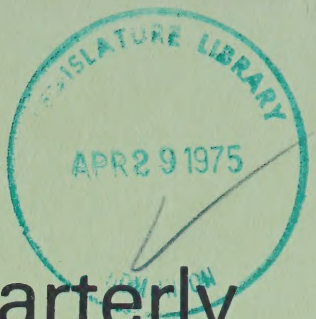

Quarterly Statistical Review

Alberta
HEALTH AND
SOCIAL DEVELOPMENT
Research and Planning Division

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APRIL - JUNE 1974

Notes:

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CHARACTERISTICS OF PUBLIC ASSISTANCE CLOSED CASES

Vivien Lai*

INTRODUCTION

In previous issues of the Quarterly Statistical Review, characteristics of the active public assistance caseload have been presented, and trends have been analyzed.[1] Considerable interest has been expressed concerning characteristics of public assistance closed cases, that is, those recipients who have ceased receiving assistance. Questions asked include: What are the characteristics of public assistance recipients who managed to get off welfare? Are their characteristics very different from recipients who stay on welfare? What are the major reasons for closure? The objective of the article is to present the characteristics of public assistance closed cases, as well as to look at their shift in characteristics between 1970 and 1974.

This paper will be divided into two sections. Section I will analyse characteristics of cases that were closed between January 1970 and March 1973, dealing with their reason for assistance, age distribution, duration of assistance, and reason for closure, as well as comparing and contrasting these characteristics with active cases. Section II will look at the shifts in characteristics of closed cases from April 1971 to the present.

Section I: Characteristics of Closed Cases, January 1970 - March 1973

Since January 1970, Alberta Health and Social Development has maintained a computerized statistical system on public assistance recipients. In March 1973, a special analysis was prepared showing characteristics of cases that were closed in the period January 1970 to March 1973. All cases included in the study received assistance for some interval of time during the study period, but their files were closed as of March 1973, indicating that they were off assistance at that date. These cases will now be discussed according to four characteristics.

(a) Reason for Assistance

Table 1 compares active and closed cases by reason for assistance for the period January 1970 to March 1973. The table shows that there is great varia-

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[1]Refer to "Socio-Demographic Profile of the Public Assistance Caseload, 1970/71 - 1972/73" by Vivien Lai and C. Collis, January - March 1973, Quarterly Statistical Review, Alberta Health and Social Development.

tion between the active and closed cases in their percentage distribution by reason for assistance. Forty per cent of the closed cases were categorized as unemployed employables, whereas only fourteen per cent of the active cases fell into this category.

As a pattern, closed cases were substantially over-represented in groups on assistance by reason of lack of employment, whereas active cases were over-represented in groups that were on assistance by reason of sickness, age or support of dependent children. This indicates that the former groups tend to get off assistance at a faster rate than the latter.

(b) Age

Table 2 shows the age distribution of household heads of open and closed cases from January 1970 to March 1973. In general, the age of household heads of closed cases was younger than that of the active cases. Thirty-five per cent of closed cases were under 25 years, whereas only sixteen per cent of active cases came from this age group. Only 24 per cent of closed cases were over 45 years of age, whereas 48 per cent of active cases were above 45 years. This shows that cases from younger age groups tend to get off assistance faster than other age groups. Since the reason a person came into assistance is highly affected by his age (for example, unemployed employable cases tend to come from younger age groups, and age and physical ill health cases from older age groups), it can be said that younger age groups get off assistance faster than other cases because they may more likely be employable cases.

An attempt was made to test whether age by itself is a controlling factor influencing the rate of getting off assistance, irrespective of reasons for assistance. Table 3 shows the comparison of the age distribution of active and closed cases by reasons for assistance. It is shown that, for all reasons for assistance, closed cases were younger in distribution than active cases. This means that, holding constant reasons for assistance, age is demonstrated to have an influence on closure; the younger age groups tend to get off assistance faster than the older age groups, irrespective of reasons for assistance.

(c) Duration on Assistance

Table 4 shows duration of assistance for active and closed cases. In general, the majority of closed cases was on assistance for a very short period; 57 per cent were on for less than three months, and 81 per cent were on assistance for less than one year. For active cases, the percentage distribution was very different. Forty-one per cent were on assistance for less than one year, 16 per cent between one and two years, and 11 per cent between two and three years. Twenty per cent of cases were on assistance for more than five years. The contrast of duration of assistance of the active and closed cases

seems to indicate that there were two distinct groups of persons on assistance: a group of short-term cases which tended to use assistance as a stop-gap measure and were usually off assistance within a few months (the majority of these cases being unemployed employables), and another group of long-term cases which was on assistance for more than five years (the majority of these cases being on assistance by reason of age and physical ill health).

The most interesting observation from this data on duration of assistance was the extremely short length of time the unemployed employable cases were on assistance. Seventy-eight per cent of closed cases of unemployed employables were closed within the first three months on assistance. Less than 25 per cent of active unemployed employables had been on assistance for more than one year. Fathers with dependent children and employed with insufficient income closed cases appear to have the shortest duration of assistance next to unemployed employables. Active age and physical ill health cases had the longest length on assistance; 45 per cent of the former and 41 per cent of the latter were on assistance for more than three years. Mothers with dependent children appear to be equally split between long- and short-term cases. Forty-one per cent of active cases were on assistance for less than a year, whereas 30 per cent were on assistance for more than three years.

(d) Reason for Closure

Table 5 shows the distribution of closed cases by reason for closure. The majority of these cases were closed for the following reasons: no return to regional office (37 per cent), location of employment (24 per cent), revenue and assets in excess of allowable amount (20 per cent), and reunification of family and marriage (9 per cent).

Looking at the relationship of reason for closure with reason for assistance on one hand, and reason for closure and age of household head on the other (Tables 5 and 6), the former relationship is much more obvious than the latter. That is, the circumstances in which a person gets off welfare are greatly related to the circumstances in which he/she gets on welfare. As examples, for employable cases, location of employment was the major reason for closure; for mothers with dependent children, closure by reunification with family, marriage, and common law union were substantially more important than other reasons for assistance (36 per cent, only 11 per cent for total cases); for old age cases on assistance, the major reason for closure was assets and revenue in excess of allowable amount. Distribution of reasons for closure for ill health cases was similar to that of the general distribution of total caseload.

Regarding reason for closure by age distribution, Table 6 shows that the reasons did not vary substantially by age. The only exception to this is the

reason for closure for the age group 65 years and over. Eight-one per cent of closed cases in this age group were closed by reason of "revenue and/or assets in excess of allowable amount". This probably is the impact of the federal programs of Old Age Security and Guaranteed Income Supplement which are only available to persons 65 years of age and older.

Section II: Shifts in Characteristics of Closed Cases, March 1973 - November 1974[2]

The above discussion compares the characteristics of open and closed cases for the study period of January 1970 to March 1973. Because caseload characteristics have changed somewhat since March 1973, an attempt was made to see whether the above analyses were applicable to the caseload from March 1973 to the present.

Comparisons of the percentage distribution of open and closed cases by reasons for assistance were prepared for the periods April 1971 to February 1974 and March 1974 to November 1974.[3] The comparison for the most recent period is shown in Table 7. The percentage differences between active and closed cases by reason for assistance as shown in the previous section were maintained in the recent assistance caseload. This means that the unemployed employable caseload is still shown to be getting off assistance at a substantially faster rate than other cases. Cases on assistance by reason of old age were substantially under-represented in the closed cases, showing that they tended to stay on assistance longer than other types of cases.

Table 8 shows the comparison of the age distributions of active and closed cases for the periods January 1970 - March 1973, April 1973 - February 1974, and March 1974 - November 1974. The former finding showing that younger age groups (below 44 years) get off assistance at a faster rate than older age groups is still consistently applicable to the statistics of the most recent periods.

Comparison of duration of assistance of closed cases for the three periods since January 1970 shows interesting differences (Table 9). It appears that since March 1974, the duration of assistance for closed cases has increased. Forty-six per cent of closed cases from March 1974 to November 1974 were on assistance for less than three months, whereas the percentage for April 1973

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[2] These are the latest months for which statistics were available at the time this article was prepared.

[3] Only the tables for the period March to November 1974 have been produced in this article. Tables for April 1973 to February 1974 are available on request.

to February 1974 was 57 per cent. The reasons for this cannot be specified until further analyses are available. However, preliminary analyses seem to indicate that this trend is related to the improved economy of Alberta in the last year. It appears that some long-term public assistance cases were able to take opportunities in the improved economy and get off welfare, whereas previously they were not able to do so. This, of course, lengthens the average duration on assistance of closed cases. This explanation is substantiated by the fact that there was a 2.4 per cent decrease in the public assistance caseload between the periods March 1974 - November 1974 and April 1973 - February 1974 (from 29,997 to 29,265).

Table 10 shows reasons for closure for cases closed between March 1974 and November 1974. Owing to the change of coding methods and the conversion to a new statistical system in March 1974, statistics for this period are not directly comparable to those of the previous intervals. However, as previously observed, the following reasons were still major reasons for closure: location of employment (39 per cent), whereabouts unknown (27 per cent), and marriage and reconciliation with spouse (11 per cent). It should be noted that the location of employment as a reason for closure has increased from 24 per cent of closed cases in 1973 to 39 per cent in 1974. Part of this is the result of the change to a new statistical system where the reporting mechanism is improved. As can be noted, the category 'closing for unknown reasons' has decreased for this period. However, part of the reason for the increased percentage of closure by employment is the improved economy in Alberta in the year 1974.

SUMMARY

This paper analyses the characteristics of public assistance cases who were on welfare at certain points in time but who managed to get off assistance. The analyses show that persons on assistance by reason of unemployment usually stayed on assistance for a very short period of time (less than three months) and they usually got off assistance at a faster rate than other cases. Age and ill health cases usually stayed on assistance longer. Mothers with dependent children were split between long-term and short-term cases.

The reasons for closure for assistance cases were found to be related considerably to the reasons and circumstances leading the persons to assistance in the first instance. For example, unemployed employables were found to be getting off welfare by reason of employment, and mothers with dependent children by reasons of marriage and reunification of family, to a greater extent than other categories were getting off assistance for these reasons. Irrespective of other circumstances, youth is a factor in shortening the duration of

assistance.

The above observations were found to be consistent throughout the periods from 1970 to present. It appears that, in view of the improvement of the economy in Alberta in the year 1974, location of employment has increased as an important factor leading to closure of cases. As well, relatively long-term cases were able to get off assistance with these increased opportunities.

TABLE 1 PERCENTAGE DISTRIBUTION OF CLOSED CASES AND AVERAGE MONTHLY ACTIVE CASELOAD BY REASON FOR ASSISTANCE, ALBERTA, JANUARY 1970 - MARCH 1973

Reason for Assistance	Closed Cases	Average Monthly Active Caseload	Difference (Closed-Active)
Age 60+	9.26	16.06	-6.80
Physical Ill Health	17.02	25.66	-8.64
Mental Ill Health	2.93	7.40	-4.47
Employed with Insufficient Income	7.10	5.33	1.77
Mother with Dependent Children	22.75	31.45	-8.70
Father with Dependent Children	0.62	0.41	0.21
Unemployed Employables	40.32	13.69	26.63
TOTAL	100.00	100.00	
Number of Cases	52357	28472	

TABLE 2 PERCENTAGE DISTRIBUTION OF CLOSED CASES AND AVERAGE MONTHLY ACTIVE CASELOAD, BY AGE GROUP, ALBERTA, JANUARY 1970 - MARCH 1973

Age Group	Closed Cases	Average Monthly Active Caseload	Difference (Closed-Active)
0 - 24	35.21	16.05	19.16
25 - 44	41.19	36.14	5.05
45 - 64	13.98	35.79	-21.81
65+	9.62	12.02	-2.40
TOTAL	100.00	100.00	
Number of Cases	52357	28419[a]	

[a]The average number of active cases is actually 28472. The discrepancy results from a few records where age data is missing.

TABLE 3 COMPARISON OF THE PERCENTAGE AGE DISTRIBUTIONS OF CLOSED CASES AND AVERAGE MONTHLY ACTIVE CASELOAD, BY REASON FOR ASSISTANCE, ALBERTA, JANUARY 1970 - MARCH 1973

Reason for Assistance	0 - 24	25 - 44	45 - 64	65+	TOTAL	Number of Cases
Age 60+						
Closed Cases	-	-	21.39	78.61	100.00	4,847
Average Monthly Active Caseload	-	-	48.09	51.91	100.00	4,676
Difference (C - A)	-	-	-26.70	26.70	-	-
Physical Ill Health						
Closed Cases	30.82	30.31	27.24	11.63	100.00	8,913
Average Monthly Active Caseload	10.65	19.69	61.50	8.16	100.00	7,278
Difference (C - A)	20.17	10.62	-34.26	3.47	-	-
Mental Ill Health						
Closed Cases	34.88	40.28	18.19	6.65	100.00	1,534
Average Monthly Active Caseload	25.00	36.35	36.68	1.97	100.00	2,132
Difference (C - A)	9.88	3.93	-18.49	4.68	-	-
Employed with Insufficient Income						
Closed Cases	25.95	58.78	14.30	0.97	100.00	3,719
Average Monthly Active Caseload	13.82	57.72	27.24	1.22	100.00	1,476
Difference (C - A)	12.13	1.06	-12.94	-0.25	-	-
Mothers with Dependent Children						
Closed Cases	36.74	54.71	8.47	0.08	100.00	11,911
Average Monthly Active Caseload	21.21	59.43	19.22	0.14	100.00	9,066
Difference (C - A)	15.53	-4.72	-10.75	-0.06	-	-
Fathers with Dependent Children						
Closed Cases	11.46	63.78	23.21	1.55	100.00	323
Average Monthly Active Caseload	3.30	46.28	42.98	7.44	100.00	121
Difference (C - A)	8.16	17.50	-19.77	-5.89	-	-
Unemployed Employables						
Closed Cases	46.08	44.25	9.50	0.17	100.00	21,110
Average Monthly Active Caseload	36.99	44.35	18.38	0.28	100.00	3,901
Difference (C - A)	9.09	-0.10	-8.88	-0.11	-	-
TOTAL						
Closed Cases	35.12	41.19	14.07	9.62	100.00	52,357
Average Monthly Active Caseload	17.04	35.72	36.37	10.87	100.00	28,650[a]
Difference (C - A)	18.08	5.47	-22.30	-1.25	-	-

[a]The discrepancy from the 28,472 average caseload by reason for assistance is the result of being able to use only 29 of the 36 monthly figures on age, while data by reason for assistance were available for the total 36 month period from April 1970 to March 1973.

TABLE 4 COMPARISON OF THE PERCENTAGE DISTRIBUTIONS OF CLOSED AND ACTIVE CASES BY DURATION OF ASSISTANCE AND REASON FOR ASSISTANCE, ALBERTA, MARCH 1973

Duration of Assistance (Months)	Reason for Assistance																Difference (C - A)
	Age 60+		Physical Ill Health		Mental Ill Health		Employed with Insufficient Income		Mother with Dependent Children		Father with Dependent Children		Unemployed Employables		TOTAL		
	Closed	Active	Closed	Active	Closed	Active	Closed	Active	Closed	Active	Closed	Active	Closed	Active	Closed	Active	
0 - 3	22.26	9.95	50.34	15.75	44.39	13.15	49.88	16.90	43.08	17.61	71.21	27.97	78.08	46.98	57.20	19.66	37.54
4 - 12	22.14	15.91	28.60	17.61	29.98	18.67	27.97	26.53	31.65	23.78	19.81	25.87	17.93	28.57	24.33	21.46	2.87
13 - 24	18.18	16.28	8.59	14.11	12.07	17.77	10.54	15.81	11.86	17.58	4.95	13.99	2.83	10.75	8.11	15.52	-7.41
25 - 36	8.04	12.88	3.69	11.33	5.35	14.13	4.19	11.17	4.68	11.08	1.86	9.09	0.68	5.43	3.18	10.88	-7.70
37 - 59	11.99	16.60	4.00	14.27	4.56	19.41	3.84	14.00	4.33	11.10	1.24	11.19	0.27	4.59	3.30	12.63	-9.33
60+	17.39	28.38	4.78	26.93	3.65	16.87	3.58	15.59	4.40	18.85	0.93	11.89	0.21	3.68	3.88	19.85	-15.97
TOTAL	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	
Number of Cases	4847	4465	8913	7353	1534	2442	3719	1379	11911	10010	323	143	21110	4074	52357	29866	

TABLE 5 PERCENTAGE DISTRIBUTION OF CLOSED CASES BY REASON FOR CLOSURE AND REASON FOR ASSISTANCE, ALBERTA, MARCH 1973

Reason for Closure	Age 60+	Physical Ill Health	Mental Ill Health	Employed with Insufficient Income	Mother with Dependent Children	Father with Dependent Children	Unemployed Employable	TOTAL
Reuniting of Family	1.07	2.57	3.32	3.42	18.41	1.86	1.40	5.64
Marriage	1.26	2.75	3.13	3.82	10.49	0.31	0.66	3.60
Death	0.04	0.11	0.13	-	0.01	-	-	0.03
Entered Common Law Union	0.21	1.59	1.89	1.42	6.79	0.31	0.61	2.24
Employed	4.58	22.39	22.30	29.42	16.95	32.20	32.71	24.23
Left Alberta	4.77	8.00	9.65	4.17	10.59	6.50	5.64	7.10
No Return to Regional Office	14.17	38.23	41.00	32.76	25.27	41.17	48.83	37.04
Revenue and/or Assets in Excess of Allowable Amount	73.90	24.36	18.58	24.99	11.49	17.65	10.15	20.12
TOTAL	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Number of Cases	4,847	8,913	1,534	3,718	11,911	323	21,110	52,356

TABLE 6 PERCENTAGE DISTRIBUTION OF CLOSED CASES BY REASON FOR CLOSURE AND AGE GROUP, ALBERTA, MARCH 1973

Reason for Closure	Age Group 0 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65+	TOTAL
Reuniting of Family	6.81	6.36	7.53	6.81	6.30	5.64	4.69	4.92	3.42	2.50	0.40	5.64
Marriage	4.23	4.12	3.98	3.98	4.71	3.95	3.15	3.02	2.60	2.61	0.60	3.60
Death	0.02	-	-	0.02	0.02	0.11	-	0.05	0.07	0.07	0.09	0.03
Entered Common Law Union	2.05	2.62	2.93	2.83	2.89	2.78	1.78	1.30	0.89	0.74	0.13	2.24
Employed	24.33	27.41	27.09	28.03	27.08	27.16	27.67	26.94	24.64	17.07	2.85	24.23
Left Alberta	7.58	7.33	7.93	7.77	7.08	7.00	6.30	7.71	7.32	10.30	3.54	7.10
No Return to Regional Office	47.78	43.21	39.91	38.71	38.02	38.51	38.05	34.14	34.09	30.10	11.62	37.04
Revenue and/or Assets in Excess of Allowable Amount	7.20	8.95	10.63	11.84	13.90	14.85	18.36	21.92	26.97	35.61	80.77	20.12
TOTAL	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Number of Cases	3761	11092	9566	6266	4634	3744	2859	2153	1461	1359	5501	52356

TABLE 7 PERCENTAGE DISTRIBUTION OF CLOSED CASES AND AVERAGE MONTHLY ACTIVE CASELOAD BY REASON FOR ASSISTANCE, ALBERTA, MARCH - NOVEMBER 1974

Reason for Assistance[a]	Closed Cases	Average Monthly Active Caseload	Difference (C - A)
Age	8.25	21.48	-13.23
Physical Ill Health/ Disabled	14.30	18.73	-4.43
Mental Illness	4.17	7.47	-3.30
Mental Retardation	0.36	0.89	-0.53
Employables	39.27	11.52	27.75
Persons with Dependent Children	33.16	39.26	-6.10
Unsuited for Employment	0.49	0.65	-0.16
TOTAL	100.00	100.00	
Number of Cases	19,292	29,265	

[a]The development of new definitions for reasons for assistance as the result of introduction of a new statistical system in March 1974 precluded comparability with the previous tables.

TABLE 8 PERCENTAGE DISTRIBUTION OF CLOSED CASES AND AVERAGE MONTHLY ACTIVE CASELOAD BY AGE GROUP, ALBERTA, JANUARY 1970 - NOVEMBER 1974

Reason for Assistance	0 - 24	25 - 44	45 - 64	65+	TOTAL	Number of Cases
January 1970 - March 1973						
Closed Cases	35.21	41.19	13.98	9.62	100.00	52,357
Average Monthly Active Caseload	16.05	36.14	35.79	12.02	100.00	28,419[a]
Difference (C - A)	19.16	5.05	-21.81	-2.40	-	-
April 1973 - February 1974						
Closed Cases	35.77	43.94	15.11	5.18	100.00	21,852
Average Monthly Active Caseload	17.16	37.12	35.90	9.82	100.00	29,977
Difference (C - A)	18.61	6.82	-20.79	-4.64	-	-
March 1974 - November 1974						
Closed Cases	35.63	43.65	15.79	4.93	100.00	19,292
Average Monthly Active Caseload	17.96	36.45	36.15	9.44	100.00	29,265
Difference (C - A)	17.67	7.20	-20.36	-4.51	-	-

[a]The average caseload for this period is 28,472; the discrepancy results from a few records where age data is missing.

TABLE 9 DURATION OF ASSISTANCE FOR CLOSED CASES, ALBERTA, JANUARY 1970 - NOVEMBER 1974

Duration of Assistance (Months)	January 70-March 73	April 73-February 74	March 74-November 74
0 - 3	57.20	56.80	45.75
4 - 12	24.33	24.46	29.60
13 - 24	8.11	8.10	10.08
25 - 36	3.18	3.70	4.59
37 - 59	3.30	3.33	4.71
60+	3.88	3.62	5.27
TOTAL	100.00	100.00	100.00
Number of Cases	52,357	21,852	17,519

TABLE 10 PERCENTAGE DISTRIBUTION OF CLOSED CASES BY REASON FOR CLOSURE AND REASON FOR ASSISTANCE, ALBERTA, MARCH 1974 - NOVEMBER 1974

Reason for Closure	Reason for Assistance							
	Age 60+	Person with Dependent Children	Physical Ill Health/ Disability	Mental Ill Health	Mental Retardation	Employable	Unsuited for Employment	TOTAL
Death	12.31	0.63	5.54	3.59	-	0.22	2.30	2.26
Employment Income	10.86	30.74	33.58	27.49	45.16	54.93	14.94	38.88
Received OAS/GIS	20.89	0.02	-	-	-	0.03	-	1.76
Excess Income	7.19	4.75	8.60	3.87	3.23	3.31	2.30	4.87
Excess Cash Assets	16.52	3.24	4.73	3.87	-	1.73	1.15	3.97
Left Province	6.85	8.23	5.54	5.80	4.84	3.03	4.60	5.55
Treaty Indian on Reserve	0.07	0.16	-	-	-	0.16	-	0.12
Non-Indian on Reserve	0.07	-	0.04	-	-	0.06	-	0.03
Married or Common-Law	1.11	13.99	3.22	3.18	3.23	0.98	3.45	5.71
Reconciled with Spouse	0.55	13.03	1.96	1.10	1.61	0.53	4.60	4.91
Refused Information	0.55	0.38	0.77	0.28	-	0.39	-	0.45
Institutionalized	3.04	0.14	0.98	10.22	9.67	0.53	4.60	1.13
Whereabouts Unknown	15.01	21.80	30.56	35.22	20.97	30.33	48.27	26.53
Refused Employment	-	0.05	0.16	0.41	-	0.48	-	0.25
Other	4.98	2.84	4.32	4.97	11.29	3.29	13.79	3.58
TOTAL	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Number of Cases	1446	5733	2454	724	62	6861	87	17367

O.A.S. - Old Age Supplement
G.I.S. - Guaranteed Income Supplement

USE OF SHOPPING CENTRES IN SCREENING FOR HYPERTENSION*

Dr. D.S. Silverberg, Dr. E.S.O. Smith, Barbara Juchli
and Elsie VanDorsser**

SUMMARY

In two Edmonton shopping centres 9591 people were screened for hypertension: 3.3 per cent were found to be normotensive but taking antihypertensive medication and another 8.8 per cent were found to have elevated blood pressure. Systolic hypertension alone accounted for 45.3 per cent of the hypertensive cases and diastolic hypertension with or without systolic, for 54 per cent. Of the group with elevated blood pressure 34.5 per cent had been previously unaware of their condition, 18.7 per cent had never received medication for it, 18.2 per cent had received medication in the past but had discontinued it, 26.1 per cent were still on medication and 2.5 per cent were not taking antihypertensive medication and were uncertain if they had ever done so in the past. Eight-eight per cent of the hypertensives who were receiving no medication went to their physician; 41 per cent were prescribed antihypertensive medication, and 87 per cent were still on treatment three months later and 74 per cent one year after detection. Eighteen per cent of those started on treatment had their medication discontinued by their doctor over the next year and 8 per cent stopped treatment on their own. Of those hypertensives already receiving medication 88 per cent went to their doctor and 33 per cent had their medication altered.

Physician measurements of blood pressure tended to be lower than those recorded at the screening. At least part of the explanation for this discrepancy is that physicians often used blood pressure cuffs that were too wide for the patient's arm; 25 per cent of the people screened required cuffs narrower than the standard cuff used by most physicians.

The prevalence of hypertension was similar among women taking oral contraceptives and woman not taking these agents.

INTRODUCTION

Surveys estimate that between 10 and 15 per cent of the adult population has hypertension and in the majority it is undetected, untreated or inade-

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quately treated.[1-3] By the time hypertension is discovered many people have evidence of damage to the heart,[4-6] kidneys,[4] eyes,[5] or other organs. Yet the benefits of early treatment in preventing cardiovascular complications are now well established.[7-10] In people under the age of 65 in the United States the cost of hypertensive complications is estimated to be five billion dollars per year.[11]

How can the hypertensive who is not regularly visiting a physician be found? Door-to-door screening has been found to be inefficient because people are often not at home or refuse entry to the interviewer.[1,2] Screening for high blood pressure in shopping centres, however, appears to be a satisifactory method, for it attracts large numbers of people of both sexes, of all ages and from all walks of life.[1,2]

MATERIALS AND METHODS

Volunteers

Nursing alumni groups throughout the city were told about the recent advances in hypertension treatment and the importance of detecting the untreated hypertensive. Over 200 nurses volunteered time for the screening project, and the services of another 100 volunteers, both medical and lay people, were obtained through free radio, television and press advertisements.

Training

Several churches offered their auditoriums as training areas. The volunteers were given printed information and attended lectures on the anatomy and physiology of the heart and circulation, the epidemiology of hypertension and the principles and benefits of dietary and drug treatment. They also received instruction concerning the completion of the questionnaire to be used in the project. In order to qualify as interviewers the volunteers were required to pass a practical test of determining blood pressure.

Physician education

Prior to the initiation of the screening survey a brochure was prepared that reviewed recent concepts in hypertension and provided guidelines for work-up and treatment. This brochure was prepared in cooperation with the Alberta Medical Association and local and provincial health departments, and was sent to all Edmonton practitioners.

Public Education

General information on hypertension and details of the screening program

itself were disseminated through radio and television broadcasts and in the press. In their monthly advertising flyers both shopping centres advertised the screening project.

A single-page information sheet and two booklets on hypertension (prepared by Merck, Sharp & Dohme Canada Ltd. and G. D. Searle & Co. of Canada Ltd.) were distributed at the screening booths. These pamphlets explained what high blood pressure is, what causes it and why it merits treatment.

Blood pressure booths

Several signs throughout the shopping centres and posted around the booths advertised the project. Each screening area was within the actual shopping complex but in one of the less noisy areas. Three or four volunteers were in attendance at any one time depending upon the time of day. A row of chairs outside the booths allowed people to sit and peruse the literature provided while waiting for their blood pressure measurement. The actual screening area was enclosed by curtains supported by aluminum rods. The area was divided into four booths, each five feet square. Each booth was furnished with two chairs and a table.

Interview questionnaire

In addition to standard demographic data and the manometer readings the interview form included questions about history of hypertension and the use of contraceptive pills. Interviews lasted an average of five minutes. The blood pressure was recorded at the beginning and at the close.

Equipment

Mercury manometers were employed with blood pressure cuffs of different widths since the ideal cuff width is 20 per cent more than the diameter of the arm.[12]

The diastolic blood pressure was recorded as the point where the Korotkoff sounds disappeared or, if the sounds failed to disappear, the point at which they became muffled. Where possible the blood pressure was measured in the right arm while the patient was seated.

Hypertension standards

The lower of two systolic readings and the lower of two diastolic readings were recorded as the individual's pressure. A person was considered to have high blood pressure if either the lower systolic or the lower diastolic pressure was at hypertensive level according to the schedule in Table 1.

Diastolic hypertension was classified as "mild" when the diastolic blood

pressure was less than 104, "moderate" when its range was from 105 to 114 and "severe" when it exceeded 114 mm Hg.

Post-survey contact of hypertensive subjects

Three months after the initial interview a sample of the individuals identified as hypertensive were contacted by telephone to determine whether they had gone to their physician, whether he had prescribed medication or a diet and whether they had continued the recommended treatment. If they had not seen a physician or had discontinued the prescribed medication the reasons were recorded. After a further period of three months those who had previously reported they had not seen a doctor were contacted again to determine if they had seen a doctor subsequent to the first telephone call. One year after detection 100 of those who had been placed on medication and were still taking it three months later were called again to ascertain whether they were still on treatment.

Survey of medical records of hypertensive subjects

Medical records were obtained from the physicians of 204 patients who were on no medication, had been told that their blood pressure was elevated and had subsequently visited a doctor. The group's average blood pressure measured in the shopping centre was compared with the average blood pressure taken by the physician.

RESULTS

Public response

The booths in the first shopping centre were in operation Monday through Friday for 12 hours a day (10:00 a.m. to 10:00 p.m.). An average of 125 people per day had their blood pressure taken.

An average of only 88 people per day visited the booths at the second shopping centre but at this one shorter operating hours were in effect. Monday through Wednesday the booth was open 7 1/2 hours (10:00 a.m. to 5:30 p.m.) and averaged 62 people per day. The average rose to 114 on Thursdays and Fridays when it was open 11 hours (10:00 a.m. to 9:00 p.m.) and to 112 on Saturdays when the booth was open 7 1/2 hours (10:00 a.m. to 5:30 p.m.).

Prevalence and type of hypertension

A total of 9591 people were screened; 45 per cent were male and 55 per cent were female. Elevated blood pressure was found in 844 (8.8 per cent) individuals, 393 (9.2 per cent) males and 451 (8.5 per cent) females (Table 2).

Of the 844 hypertensive cases systolic hypertension without diastolic hypertension occurred in 382 (45.3 per cent) - in 16 (18.6 per cent) of 86 cases in the less-than-40 age group, in 147 (30.9 per cent) of 476 cases in the 40-to-64 age group and in 219 (77.7 per cent) of 282 cases in the 65-and-over age group.

The other 54.7 per cent of hypertensive individuals had diastolic hypertension with or without systolic hypertension. In 69.3 per cent it was mild, in 22.3 per cent moderate and in 8.4 per cent severe (Table 3).

Treatment status

Of the people screened 314 (3.3 per cent) were taking antihypertensive medication and their blood pressure was normal. Treatment status of the 8.8 per cent whose blood pressure was elevated fell into five groups (Tables 4 and 5): 34.5 per cent were unaware of their hypertension, 18.7 per cent were aware that they had hypertension but had never taken any medication for it, 18.2 per cent were aware of their condition, had taken medication in the past but had stopped taking it, 26.1 per cent were still hypertensive while on medication, and 2.5 per cent were uncertain if they had been hypertensive in the past or had been treated for it. Thus, of the 12.1 per cent of the population that had hypertension 46.1 per cent were being treated for it (although only 58.8 per cent of these cases had normal pressure) and 53.9 per cent were not on treatment. Therefore, 72.9 per cent of the hypertensives detected were either undiagnosed, untreated or inadequately treated.

The relationship of treatment status to severity of diastolic hypertension is shown in Table 6. About one third of the persons with mild to moderate diastolic hypertension were unaware of its presence, while this was the case in only one eight of those with severe diastolic hypertension; about one quarter of those with mild or moderate diastolic hypertension were on treatment, while almost one half of those with severe diastolic hypertension were on treatment.

Effect of using the second of two blood pressure readings

When based on second reading the number of cases of hypertension was reduced from 1105 to 942. By using the lower systolic and the lower diastolic values, the number of cases was further reduced to 844. The mean blood pressure was 128.8 $\pm$ 21.4 mm Hg systolic and 75.4 $\pm$ 13.2 mm Hg diastolic on the first reading, 126.1 $\pm$ 20.8 systolic and 74.6 $\pm$ 13.2 diastolic on the second reading and 125.0 $\pm$ 20.6 systolic and 73.1 $\pm$ 13.2 diastolic when the lower systolic and diastolic values were used.

Type of cuff used

Assuming that the correct width of the blood pressure cuff exceeds the

diameter of the arm by 20 per cent,[12] it was found that the adult-type cuff (14.3 cm in width) was required in 69 per cent of cases. Narrow cuffs (11.5 cm) were required in 25 per cent and wide cuffs (15.5 cm) in 6 per cent. The narrow cuff was required in 55 per cent of people 20 years old and less, in 25 per cent of those between the ages of 21 and 30 and in 16.8 per cent of those over the age of 30.

Comparison of average blood pressure of hypertensives at screening and at physician's office

As previously mentioned, the records of 204 patients with high blood pressure who visited their physician were reviewed. All 120 physicians concerned had utilized the 14.3-cm-wide adult blood pressure cuffs. Employing standards as previously outlined, 75 per cent of the 204 patients had hypertensive readings when their blood pressure was measured by their physician. The relationship of this reading to the one obtained at the shopping centre can be seen in Table 7. Overall, the shopping centre readings average 11.8/2.5 mm Hg higher than the physicians' readings. This difference was even more pronounced for those persons whose blood pressure had been measured with the narrow cuff at the screening and with the adult cuff by their physician: the shopping centre readings in this group averaged 14.2/8.2 mm Hg higher than the physicians' readings. Where the screening groups used a very wide cuff and the physician the usual adult cuff there was no significant difference between the two readings.

Oral contraceptives and hypertension

Of the 2087 women between the ages of 20 and 44, 394 (18.9 per cent) stated that they were taking contraceptive pills. Two per cent of these women were hypertensive in comparison with 2.8 per cent of the 1693 women not taking these agents.

The mean blood pressure for the group on contraceptive pills was 111.6 $\pm$ 13.9 mm Hg systolic and 69.5 $\pm$ 11.6 mm Hg diastolic and for the group not on contraceptive pills 115.1 $\pm$ 14.5 systolic and 70.0 $\pm$ 11.4 diastolic. There was no significant difference in the blood pressure or prevalence of hypertension between the two groups.

Follow-up of patients (see Table 5)

As explained previously, a sample of 380 hypertensive people not on medication was contacted by telephone three months after the screening. Of these, 281 (74 per cent) had visited a doctor and 99 (26 per cent) had not. After an additional three months a second phone call to the 99 persons elicited the information that by now 54 of them had seen their doctor. This means that 88

per cent of those initially found to be hypertensive and not on medication saw their doctor within six months. Of the 335 who went to see their doctor 151 (45 per cent) received treatment - 13 (4 per cent) diet alone and 138 (41 per cent) medication with or without diet. Eight-seven per cent of the hypertensives who were prescribed medication were continuing treatment at the time of the telephone contact three months after detection. The 7 per cent who had discontinued treatment had done so at their physician's request. The main reasons given by the other 6 per cent for discontinuing the medication were the presence of side effects from the drugs and failure to understand that the prescription had to be refilled. One hundred people who were still on medication three months after detection were contacted nine months later: 86 per cent were still on medication, 12 per cent had had their medication stopped by their physician and 2 per cent had stopped it on their own. Thus, of those placed on medication after detection 74 per cent were still on medication one year later, 18 per cent had had their medication stopped by their physician and 8 per cent had stopped it on their own.

In addition to the untreated hypertensives detected by the screening project 150 hypertensive people already receiving medication were contacted by telephone three months after screening. Eight-eight per cent had seen their physician within three months and one third reported that their medication had been altered. All 150 persons were continuing treatment three months later.

At what blood pressure will physicians institute treatment?

By examining the physician readings of hypertensive people it was found that physicians treated systolic hypertension in 32 per cent of cases, mild diastolic hypertension (up to 104 mm Hg) in 46 per cent, moderate diastolic hypertension (105 to 114 mm Hg) in 85 per cent and severe diastolic hypertension (more than 114 mm Hg) in 100 per cent.

Cost of screening program

During the six-month period one full-time secretary was employed at a cost of $3000. The cost of the blood pressure equipment, stationery and miscellaneous items was $2000.

DISCUSSION

The survey found 12.1 per cent of the sample population to be hypertensive, with 27 per cent of these (3.3 per cent of the total population) under control by medication. These results are not dissimilar from those reported from the United States[1-3] despite the fact that Canada, unlike the United States, has government-sponsored medical care plans to provide medical care to all its citi-

zens. Of the population tested 2.3 per cent had elevated blood pressure despite treatment and 6.5 per cent had elevated blood pressure without treatment. Of those who were not on medication 88 per cent visited their physician within six months of learning that their blood pressure was elevated. A review of the records of patients subsequent to a visit to their physician demonstrated that 75 per cent still had hypertension according to the criteria set out in this paper. Similar results have been reported for hypertensive patients in other screening surveys who had their blood pressure rechecked.[1,2,13,14]

Forty-one per cent of the previously untreated hypertensives were placed on medication: 87 per cent were still taking the medication three months after detection and 74 per cent one year after detection. Thus, of the 6.5 per cent of the total population who were hypertensive and not receiving treatment when first discovered, 31 per cent were on treatment three months later and 26 per cent one year later. Therefore, of every 25 people found to have hypertension and who were not on medication, 22 went to a physician, 17 were found to have hypertension, 9 received medication, 8 were still on medication three months after detection and 7 were still on medication one year after detection.

Why were antihypertensive agents prescribed for only 41 per cent of the hypertensive individuals who visited their physician? A review of the patients' medical records revealed that 25 per cent of the people referred did not have hypertensive levels according to their doctor's readings. There are several possible reasons for these lower readings: many people may have labile hypertension; many physicians allow the mercury column to fall at a faster rate than did the interviewers (2 to 3 mm Hg per second); and many physicians used the adult 14.3-cm cuff while a narrow 11.5-cm cuff was used at the screening, and in such cases it was found that the physician's mean blood pressure reading was 14.2/8.2 mm Hg lower than the survey reading. The use of a cuff of correct size is critical for obtaining accurate blood pressure readings[12,15] and every office, emergency room and hospital ward should be equipped with a range of sizes (this is rarely the case).

The other 75 per cent of referred individuals were, however, hypertensive both at screening and at their physician's office, yet only 41 per cent were prescribed antihypertensive medications by their physician. This may indicate that physicians disagree with the criteria used to define hypertension. Our survey found that many physicians do not treat systolic hypertension or mild diastolic hypertension as only 32 per cent of cases of the former and 46 per cent of the latter were treated. In contrast, treatment was prescribed for 85 per cent of those with moderate and 100 per cent of those with severe diastolic hypertension. There is insufficient information to determine whether treatment

of systolic or mild diastolic hypertension reduces morbidity or mortality.[8,9,16] Insurance and epidemiological statistics, however, demonstrate an increased risk in these groups.[17]

The failure of many known hypertensives to obtain adequate treatment is exemplified by the fact that 18.7 per cent of the population with elevated blood pressure had prior knowledge of their condition but had never received medication for it and 18.2 per cent had been on medication but had discontinued it. In addition, 12 per cent of the detected hypertensives failed to visit their physician and 8 per cent of those who had started treatment after going to their doctor discontinued the medication on their own. These facts reflect attitudes towards hypertension of a large portion of the general public, including those with hypertension,[18-20] and are borne out by the recent Harris survey.[19] A high percentage of the population was found to be unaware of, or had misconceptions about, what high blood pressure is, its causes and consequences and the benefits of treatment. Given the patient's probable ignorance, the development of side effects from the medication, the complexity of the drug regimen, the cost of the medication, the asymptomatic nature of the condition in its early years and the frustrations of waiting in a physician's office to have one's blood pressure checked, it is not surprising that a high percentage of patients who begin treatment fail to return to ther physician after the first few months.[20] Even when patients are instructed intensively for a prolonged period of time many will discontinue treatment if the teaching ends,[21,22] which suggests that a lifelong educational process is necessary to maintain patient compliance. The time-consuming job of patient education can be assumed by the physician, but other medical personnel such as nurses,[23] pharmacists[21] and other health aides[20] are increasingly accepting this role.

Responsibility for control of hypertension rests with physicians, local health authorities, other health personnel and the community. Involvement of physicians is essential. The Harris survey demonstrated that 68 per cent of adults in the United States see a physician each year, yet many of their examinations do not include measurement of blood pressure. If all physicians, including those in specialties such as general surgey, opthalmology, etc. included blood pressure measurement as a routine part of their examination and treated or referred hypertensives, very few hypertensives would go undetected. Similarly, if high blood pressure is noticed incidentally in the emergency room or while a patient is in hospital it should not be ignored (as is frequently the case[24,25]) but should be treated or the patient referred. In order to encourage the detection, treatment and adequate follow-up of patients, physicians must develop more positive attitudes toward the control of hypertension. Increased

emphasis must be placed on the treatment of hypertension in medical schools, residency programs and meetings of general practive and subspecialty groups.

Local health authorities could enchance public awareness of hypertension through the media, and in screening for other conditions (e.g. tuberculosis) they could include blood pressure measurement. If physicians have hypertensive patients who refuse to take medications or neglect to return for follow-up, public health nurses could be sent to their homes to extend the eudcation process. Other health personnel such as dentists,[26] pharmacists,[21] blood bank technicians[27] and physiotherapists could also routinely screen people for hypertension. Finally, community groups such as the heart or kidney foundation could increase public awareness through the media and through the organization of screening programs.

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TABLE 1 HYPERTENSIVE VALUES (IN MM HG) ACCORDING TO AGE

	Under 40	40 - 64	65 and Over
Systolic	≥155	≥160	≥165
Diastolic	≥ 95	≥ 95	≥100

TABLE 2 PREVALENCE OF SYSTOLIC AND/OR DIASTOLIC HYPERTENSION BY AGE AND SEX*

Age	MALE # of Cases	MALE Cases with High Blood Pressure #	MALE Cases with High Blood Pressure %	FEMALE # of Cases	FEMALE Cases with High Blood Pressure #	FEMALE Cases with High Blood Pressure %	TOTAL # of Cases	TOTAL Cases with High Blood Pressure #	TOTAL Cases with High Blood Pressure %
1 - 4	1	-	-	-	-	-	1	-	-
5 - 9	31	-	-	30	-	-	61	-	-
10 - 14	222	-	-	241	2	0.8	463	2	0.4
15 - 19	465	2	0.4	516	1	0.2	981	3	0.3
20 - 24	390	7	1.8	403	4	1.0	793	11	1.4
25 - 29	360	10	2.8	348	5	1.4	708	15	2.1
30 - 34	327	17	5.2	381	7	1.8	708	24	3.4
35 - 39	304	20	6.6	442	11	2.5	746	31	4.2
40 - 44	384	24	6.3	513	31	6.0	897	55	6.1
45 - 49	383	36	9.4	486	42	8.6	869	78	9.0
50 - 54	359	44	12.3	522	47	9.0	881	91	10.3
55 - 59	301	63	20.9	453	64	14.1	754	127	16.8
60 - 64	252	58	23.0	361	67	18.6	613	125	20.4
65 - 69	252	46	18.2	299	68	22.7	551	114	20.7
70 - 74	151	41	27.2	192	53	27.6	343	94	27.4
75+	94	25	26.6	124	49	39.5	218	74	33.9
TOTAL	4276	393	9.2	5311	451	8.5	9587	844	8.8

*Four people who refused to give their age are not included in the table.

TABLE 3 RELATIONSHIP OF SEVERITY OF DIASTOLIC HYPERTENSION TO AGE*

Age	Severity of Diastolic Hypertension						
	Mild		Moderate		Severe		
	# of Cases	% of Age Group	# of Cases	% of Age Group	# of Cases	% of Age Group	Total
<40	55	78.6	12	17.1	3	4.3	70
40 - 64	233	70.8	72	21.9	24	7.3	329
>64	32	50.8	19	30.2	12	19.0	63
Total	320	69.3	103	22.3	39	8.4	462

*"Mild" diastolic hypertension: age <65, 95 - 104 mm Hg. Ages 65 and above, 100 to 104 mm Hg.

"Moderate" diastolic hypertension: 105 - 114 mm Hg at all ages.

"Severe" diastolic hypertension: >114 mm Hg at all ages.

TABLE 4 FINDINGS FROM THE SURVEY AND POST-SURVEY FOLLOW-UP

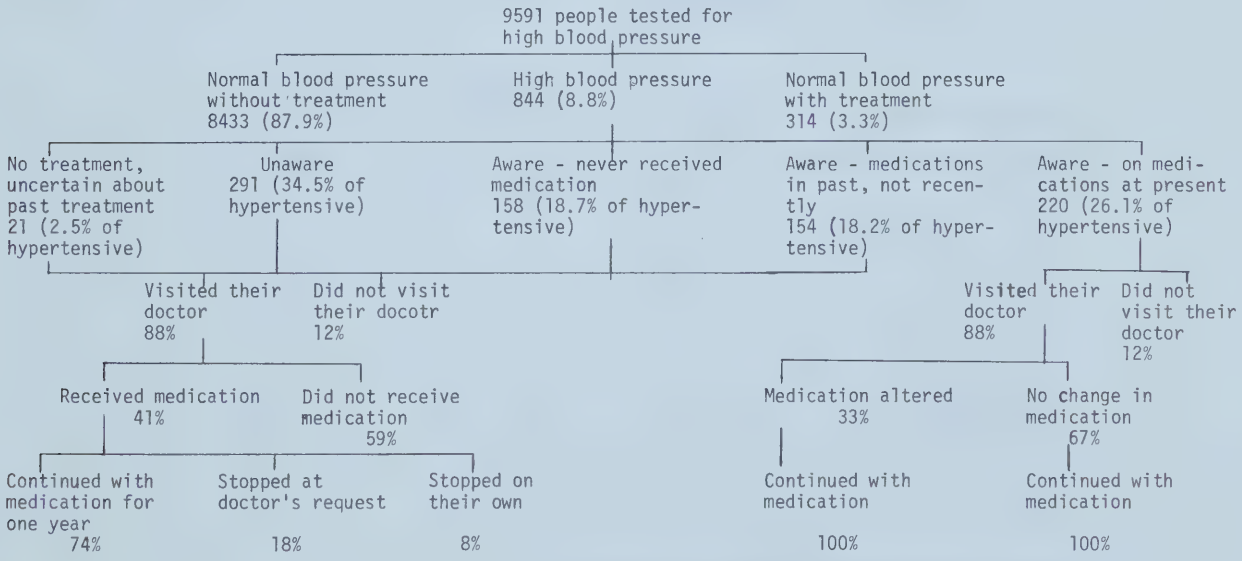
9591 people tested for high blood pressure
Normal blood pressure without treatment 8433 (87.9%)
High blood pressure 844 (8.8%)
Normal blood pressure with treatment 314 (3.3%)
No treatment, uncertain about past treatment 21 (2.5% of hypertensive)
Unaware 291 (34.5% of hypertensive)
Aware - never received medication 158 (18.7% of hypertensive)
Aware - medications in past, not recently 154 (18.2% of hypertensive)
Aware - on medications at present 220 (26.1% of hypertensive)
Visited their doctor 88%
Did not visit their docotr 12%
Visited their doctor 88%
Did not visit their doctor 12%
Received medication 41%
Did not receive medication 59%
Medication altered 33%
No change in medication 67%
Continued with medication for one year 74%
Stopped at doctor's request 18%
Stopped on their own 8%
Continued with medication 100%
Continued with medication 100%

TABLE 5 RELATIONSHIP OF TREATMENT STATUS IN SYSTOLIC AND/OR DIASTOLIC HYPERTENSION AND AGE*

Age	< 40 Cases		40 - 64 Cases		> 64 Cases		Total Cases	
Treatment Status	#	%	#	%	#	%	#	%
Unaware	43	50.6	153	33.1	95	34.4	291	35.4
Aware - never took medication	19	22.4	95	20.6	44	15.9	158	19.2
Aware - stopped medication	12	14.1	90	19.5	52	18.8	154	18.7
Aware - on medication	11	12.9	124	26.8	85	30.8	220	25.7
Total	85	100.0	462	100.0	276	100.0	823	100.0

*Excluded are 21 hypertensive individuals who were not sure of their treatment status.

TABLE 6 RELATIONSHIP OF TREATMENT STATUS OF HYPERTENSIVES TO SEVERITY OF DIASTOLIC HYPERTENSION*

Treatment Status	Mild Cases		Moderate Cases		Severe Cases	
	#	%	#	%	#	%
Unaware	114	36.7	34	32.7	5	13.5
Aware - never took medication	61	19.6	19	18.3	8	21.6
Aware - stopped medication	54	17.4	28	26.9	8	21.6
Aware - on medication	82	26.4	23	22.1	16	43.2
Total	311	100.0	104	100.0	37	100.0

*See definitions in Table 3 footnote.

TABLE 7 COMPARISON OF BLOOD PRESSURE OBTAINED BY SCREENING GROUP AND BY PHYSICIANS, USING DIFFERENT SIZED CUFFS

Group	No.	Mean (mm Hg)	Standard Deviation (mm Hg)	R	Probability pf T
Overall	204				
Screening group systolic		175.5	18.1		
Physician systolic		163.7	23.1	0.46, P<0.01	<0.01
Screening group diastolic		97.4	13.2		
Physician diastolic		94.9	12.1	0.42, P<0.01	>0.05
Average Size Cuffs Used by Both Groups	138				
Screening group systolic		175.0	17.1		
Physician systolic		161.9	21.8	0.47, P<0.01	<0.01
Screening group diastolic		96.1	13.0		
Physician diastolic		94.4	11.4	0.47, P<0.01	<0.01
Narrow Cuffs Used by Screening Group, Average Size Cuffs by Physicians	41				
Screening group systolic		177.3	21.0		
Physician systolic		163.1	22.1	0.53, P<0.01	<0.01
Screening group diastolic		101.6	13.4		
Physician diastolic		93.4	13.3	0.41, P<0.01	<0.01
Wide Cuffs Used by Screening Group, Average Sized Cuffs by Physician	25				
Screening group systolic		175.4	18.5		
Physician systolic		174.9	29.0	0.40, P<0.05	>0.05
Screening group diastolic		97.7	13.4		
Physician diastolic		100.2	12.9	0.34, P>0.05	>0.05

HIGHLIGHTS OF PUBLIC ASSISTANCE AND CHILD WELFARE STATISTICS

Delaine McVey and Janice Faltinson*

Public Assistance

Table 1 presents the distribution of caseload by reason for assistance for the quarter April to June 1974 and compares the distribution to that of the month of March 1974. A quarterly average for the previous quarter is not available owing to a change of the format of public assistance data beginning in March 1974. The ranking of the various reasons for seeking assistance was maintained. As observed in the month of March, persons with dependent children accounted for the largest proportion of the caseload (39.29 per cent). Persons 60 years or over constituted 21.27 per cent of the total, and those persons seeking aid due to physical illness or disability constituted 18.53 per cent. The total caseload fell from 30,148 in March to an average of 29,462 for the quarter April to June 1974. This decrease was primarily due to a drop of 531 cases (a 12.8 per cent decrease) in the category of employable persons. Substantial percentage increases in the categories of persons 60 years or over, those unsuitable for employment, and those mentally retarded did not offset the substantial absolute decrease of employable persons seeking assistance.[1]

Table 2 indicates the age-sex distribution of the caseload for the quarter April to June 1974. The proportion of the caseload constituted by males dropped to 35.10 per cent in this quarter. There was an absolute drop to 10,403 males and 19,239 females. The age group 60 - 64 years accounted for the largest number of cases for males, and women in the age groups 20 - 24 and 25 - 29 accounted for approximately 8.5 per cent each of the total caseload. The proportion of the caseload constituted by females increased from 63.64 per cent in the last quarter to 64.90 per cent in this quarter. Females in the age group 0 - 19 years substantially increased in number to 1,422 in this quarter.

Table 3 indicates the distribution of the caseload by regional office. The Edmonton and Calgary regional offices combined accounted for nearly 62 per cent of the total caseload. In contrast to the last quarter, 30 regional offices showed a decrease in the caseload, with Fort McMurray (25.13 per cent), Whitecourt (19.68 per cent), High Level (13.74 per cent) and Drumheller (9.15 per cent) experiencing the largest decreases. Only five regional offices showed

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[1]Transfers between categories of reasons for assistance are being effected gradually; i.e., the category "Unsuited for Employment" has increased from 15 in March to 160 in June, largely due to transfers from other reasons for assistance.

increases from the last quarter. These are Bonnyville (1.62 per cent), Barrhead (0.73 per cent), Slave Lake (2.27 per cent), Edson (2.74 per cent), and Edmonton West 10 (0.64 per cent).

Child Welfare

Table 1A indicates the distribution of children under care by status for the quarter April to June 1974, and compares this distribution to that of the previous quarter. The total number of children under care (6,188) increased 4.49 per cent over the previous quarter's total (5,922). Permanent wards constituted 46.9 per cent of the total; temporary wards 39.4 per cent of the total; custody by agreement and out of province cases, the remaining 13.7 per cent. Increases were evident in the proportion of the total accounted for by custody by agreement (13.02 per cent), view to adoption (9.53 per cent), temporary JDA wards (8.12 per cent), and temporary CWA wards (7.56 per cent). Permanent wards and out of province wards decreased from the previous quarter, with 1.87 per cent and 2.91 per cent, respectively.

Table 2A presents the distribution of children under care by status and type of placement. As in the previous quarter, more than one-half of the children were in foster homes (57.19 per cent). Those children placed with a view to adoption accounted for 12.23 per cent of the total; 9.45 per cent were in institutions, and 9.74 per cent were living with their own parents.

Table 3A indicates the age-sex distribution of children under care. Male children accounted for 62.13 per cent of the total; female children 37.87 per cent. This distribution is similar to that of the previous quarter. As in the previous quarter, the age range of 12 - 18 years had the greatest proportion of children (49.13 per cent), due to the inclusion of probation cases in this group.

TABLE 1 DISTRIBUTION OF CASELOAD BY REASON FOR ASSISTANCE, ALBERTA, APRIL - JUNE 1974

Reason for Assistance	March #	March %	April #	May #	June #	Quarterly Average April-June 1974 #	Quarterly Average April-June 1974 %
Persons 60 years or over	6075	20.15	6289	6341	6282	6304	21.27
Physical Illness or Disability	5693	18.88	5477	5530	5474	5494	18.53
Mental Illness	2442	8.10	2309	2263	2186	2253	7.60
Mental Retardation	18	0.06	131	222	268	207	0.70
Unsuitable for Employable	15	0.05	59	116	160	112	0.38
Persons with Dependent Children	11749	38.97	1572	11786	11582	11647	39.29
Employable	4156	13.79	3777	3717	3382	3625	12.23
TOTAL	30148	100.00	29614	29975	29334	29642	100.00
Rate of Change Over Previous Month	-2.36		-1.77	1.22	-2.14		
Rate of Change Over Previous Quarter						-2.89	

TABLE 2 AGE-SEX DISTRIBUTION OF CASELOAD, ALBERTA, APRIL - JUNE 1974

Age Group	Males		Females		Both Sexes	
	#	%	#	%	#	%
0 - 19	573	1.93	1422	4.80	1995	6.73[a]
20 - 24	894	3.01	2531	8.54	3425	11.55
25 - 29	784	2.65	2514	8.48	3298	11.13
30 - 34	650	2.19	2014	6.79	2664	8.99
35 - 39	642	2.17	1768	5.97	2410	8.13
40 - 44	796	2.69	1649	5.56	2445	8.25
45 - 49	859	2.90	1439	4.85	2298	7.75
50 - 54	878	2.96	1382	4.66	2260	7.62
55 - 59	1076	3.63	1462	4.93	2538	8.56
60 - 64	1708	5.76	1866	6.30	3574	12.06
65+	1543	5.21	1192	4.02	2735	9.23
TOTAL	10403	35.10	19239	64.90	29642	100.00

[a]The age group composition in the April - June quarter differs from that of previous quarters. This is the result of a change in the method of computing age used in the new statistical system which commenced in March 1974. Previously, age was computed using only birth year and current year. For statistics from March 1974 onward, age is computed using birth year and month. Thus, readers are reminded that differences in age group composition shown in the statistics of the January - March quarter and those of the April - June quarter are the result of changes in the definition within the statistical system and therefore not real changes in the characteristics of the welfare caseload.

TABLE 3 REGIONAL DISTRIBUTION OF CASELOAD, ALBERTA, APRIL - JUNE 1974*

Regional Office	Quarterly Average April - June 1974 #	%	Last Quarter's Average January-March 1974 #	%	Rate of Change Over Last Quarter	Rank This Quarter	Rank Last Quarter
Edmonton North	4942	16.67	4985	16.33	-0.86	1	1
Calgary South	4664	15.73	4713	15.44	-1.04	2	2
Calgary North	3243	10.94	3371	11.04	-3.80	3	3
Edmonton West	3192	10.77	3297	10.80	-3.18	4	4
Edmonton South	2260	7.62	2435	7.98	-7.19	5	5
Lethbridge	1461	4.93	1506	4.93	-2.99	6	6
West 10	947	3.20	941	3.08	+0.64	7	7
Grande Prairie	922	3.11	927	3.04	-0.54	8	8
Red Deer	803	2.71	813	2.66	-1.23	9	9
Wetaskiwin	758	2.56	797	2.61	-4.89	10	10
Medicine Hat	594	2.00	641	2.10	-7.33	11	11
High Prairie	487	1.64	507	1.66	-3.94	12	12
Barrhead	412	1.39	409	1.34	+0.73	13	13
Lac La Biche	371	1.25	386	1.26	-3.89	14	14
Vegreville	352	1.19	352	1.15	-	15	15
Peace River	337	1.14	351	1.15	-3.99	16	16
Bonnyville	313	1.06	308	1.01	+1.62	17	17
Edson	300	1.01	292	0.96	+2.74	18	19
St. Paul	292	0.99	297	0.97	-1.68	19	18
Slave Lake	270	0.91	264	0.87	+2.27	20	21
Vermilion	261	0.88	263	0.86	-0.76	21	22
Drumheller	258	0.87	284	0.93	-9.15	22	20
Camrose	239	0.81	249	0.82	-4.02	23	23
Smoky Lake	236	0.80	239	0.78	-1.26	24	24
Blairmore	223	0.76	234	0.77	-4.70	25	25
Wainwright	222	0.75	233	0.76	-4.29	26	26
Athabasca	200	0.67	204	0.67	-1.96	27	27
Stettler	164	0.55	171	0.56	-4.09	28	30
High Level	157	0.53	182	0.60	-13.74	30	29
Olds	157	0.53	170	0.56	-7.65	30	31
Rocky Mtn. House	143	0.48	157	0.51	-8.92	32	32
Fort McMurray	143	0.48	191	0.63	-25.13	32	28
Brooks	107	0.36	112	0.37	-4.46	33	34
Whitecourt	102	0.34	127	0.42	-19.68	34	33
Hanna	79	0.27	82	0.27	-3.66	35	35
Grande Cache	31	0.10	34	0.11	-8.82	36	36
TOTAL	29642	100.00	30524	100.00	-2.89		

*For comparability to Tables 1 and 2, Guardian Social Allowance has been excluded. This table shows the net social allowance and health/medical caseload.

TABLE 1A STATUS OF CHILDREN UNDER CARE, ALBERTA, APRIL - JUNE 1974

Type of Ward	April	May	June	Quarterly Average #	Quarterly Average %	Last Quarter's Average #	Last Quarter's Average %	% Change Between Quarters
Temporary C.W.A.	2009	2037	2016	2021	32.7	1879	31.7	7.56
Permanent Wards	2168	2163	2138	2156	34.8	2197	37.1	-1.87
View to Adoption	732	754	755	747	12.1	682	11.5	9.53
Temporary J.D.A.	414	420	406	413	6.7	382	6.5	8.12
Custody by Agreement	631	644	678	651	10.5	576	9.7	13.02
Out of Province	204	199	198	200	3.2	206	3.5	-2.91
TOTAL	6158	6217	6191	6188	100.0	5922	100.0	4.49
Percentage Change Over Previous Month	2.29	.96	-.42					
Percentage Change Over Previous Quarter				4.49		.03		

C.W.A. - Child Welfare Act

J.D.A. - Juvenile Delinquency Act

TABLE 2A DISTRIBUTION OF CHILDREN UNDER CARE BY STATUS AND TYPE OF PLACEMENT
ALBERTA, APRIL - JUNE 1974

Type of Placement	Temporary Ward (CWA)		Permanent Ward (CWA)		Custody by Agreement		Out of Province		Temporary Ward (JDA)		TOTAL	
	#	%	#	%	#	%	#	%	#	%	#	%
Free Home	16	0.79	21	0.72	3	0.46	2	1.00	2	0.48	44	0.71
Foster Home	1314	65.24	1628	56.10	387	59.36	141	70.50	65	15.74	3535	57.19
Institution:												
Treatment	69	3.43	75	2.58	45	6.90	1	0.50	108	26.15	298	4.82
Correctional	-	-	4	0.14	-	-	-	-	2	0.48	-	0.10
Receiving	147	7.30	73	2.52	52	7.98	3	1.50	5	1.21	280	4.53
Alberta School Hospital	11	0.55	62	2.14	17	2.61	3	1.50	1	0.24	94	1.52
Other Institution	17	0.84	95	3.27	22	3.37	4	2.00	3	0.73	141	2.28
Independent	6	0.30	29	1.00	-	-	-	-	3	0.73	38	0.61
View to Adoption	-	-	742	25.27	-	-	14	7.00	-	-	756	12.23
Run Away	36	1.79	36	1.24	9	1.38	2	1.00	38	9.20	121	1.96
With Own Parents	323	16.04	45	1.55	82	12.58	15	7.50	137	33.17	602	9.74
Group Home	46	2.28	68	2.34	28	4.29	5	2.50	35	8.47	182	2.94
With Relatives	29	1.44	24	0.83	7	1.07	10	5.00	14	3.40	84	1.36
TOTAL	2014	100.00	2902	100.00	652	100.00	200	100.00	413	100.00	6181	100.00

CWA - Child Welfare Act

JDA - Juvenile Delinquency Act

TABLE 3A AGE-SEX DISTRIBUTION OF CHILDREN UNDER CARE, ALBERTA, APRIL - JUNE 1974*

Birth Year	Males #	Males %	Females #	Females %	Both Sexes #	Both Sexes %	Approximate Age	Per Cent
1974	334	6.84	286	9.58	620	7.85	0 - 6 Years	26.82
1973	173	3.52	149	4.98	322	4.08		
1972	134	2.73	114	3.81	248	3.14		
1971	132	2.63	110	3.69	242	3.06		
1970	125	2.55	93	3.10	218	2.76		
1969	123	2.51	94	3.13	217	2.75		
1968	152	3.09	99	3.31	251	3.18		
1967	180	3.66	108	3.60	288	3.65	7 - 12 Years	24.05
1966	186	3.80	129	4.30	315	3.99		
1965	195	3.97	103	3.60	303	3.84		
1964	181	3.69	114	3.81	295	3.74		
1963	190	3.87	116	3.87	306	3.87		
1962	261	5.31	131	4.39	392	4.96		
1961	377	7.68	184	6.14	561	7.10	13+ Years	49.13
1960	562	11.46	254	8.48	816	10.33		
1959	680	13.86	333	11.17	1013	12.83		
1958	546	11.13	285	9.55	831	10.52		
1957	292	5.94	236	7.88	528	6.68		
1956	84	1.71	48	1.61	132	1.67		
TOTAL	4907	100.00	2991	100.00	7898	100.00		100.00

*Note: These tabulations include probation cases (concentrated in the ages 12 to 18 years).

HIGHLIGHTS OF NOTIFIABLE DISEASES

Barbara Juchli*

These tables and comments on notifiable diseases represent the cases reported to the divisions of local health services and social hygiene for the period April to June 1974.[1]

Table 1 shows the geographic distribution of reported cases of the more frequent notifiable diseases (excluding venereal diseases). Tables 2 and 3 illustrate the sex and age distribution of the reported cases of notifiable diseases and venereal diseases. Table 4 compares the number of cases and incidence rate of the notifiable diseases with the five-year mean, and the incidence rate for the corresponding quarter, and Table 5 compares the same information for venereal diseases.

The five most frequently reported notifiable diseases during the quarter were:

1. Gonorrhoea (1915 cases)
2. Streptococccal sore throat and scarlet fever (949 cases)
3. Measles (906 cases)
4. Infectious Hepatitis (247 cases)
5. Rubella/German Measles (227 cases)

This corresponds to the January - March quarter's list of most commonly reported notifiable diseases.

The reporting of gonorrhoea cases decreased only slightly (2.2 per cent) from the previous quarter; however, by looking at the average number of cases and incidence rates for the same months in the past five years it can be seen that the number of cases is now 59.7 per cent higher, and the incidence rate is 43.5 per cent higher for males and 71.1 per cent higher for females. It is doubtful whether much of this increase can be attributed to better reporting habits. As in the previous quarter, all cases are genito-urinary infections. Males continued to dominate the number of cases over females by a ratio of 2 to 1. Both males and females had their highest number of cases in the 20 - 24 year age group. This age group accounted for 32.7 per cent of the total gonorrhoea cases.

The reported incidence of streptococcal sore throat and scarlet fever dropped by 40.5 per cent over the January - March quarter. This quarter's number of cases is 103.7 per cent greater than the previous five-year average; the

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[1] Tuberculosis is not included in this article; venereal disease is separated from the other notifiable diseases for presentation.

incidence rate is 93.4 per cent greater than the corresponding rate. The Barons-Eureka Health Unit reported the largest number of cases (133 or 14.0 per cent). This health unit plus the cities of Edmonton and Medicine Hat accounted for 30.9 per cent of the provincial total. The 5 - 9 year age group had the highest percentage of cases (29.8 per cent) with the cases equally divided between male and female. The bordering age groups (i.e., 1 - 4 and 10 - 14) contributed 16.5 per cent and 17.3 per cent respectively giving the 1 - 14 age group 63.6 per cent of the cases.

Measles showed a dramatic 71.9 per cent jump from the January - March quarter, continuing to increase for the third consecutive quarter. The number of cases in this quarter is 67.3 per cent higher than the five year average and the incidence rate is 58.7 per cent higher for this time of year. Calgary had the largest caseload with 310 cases or 34.2 per cent. This is four times the caseload Calgary had in the previous quarter. The 5 - 9 year age group had 37.4 per cent of the cases with bordering age groups adding another 50.3 per cent.

Infectious hepatitis decreased 19.5 per cent from the previous quarter. The caseload for this period was lower (by 14.6 per cent) than for the five-year average as was the incidence rate (by 18.5 per cent). The cities of Edmonton and Calgary contributed half of the reported cases this quarter. The 15 - 19 and 20 - 24 year age groups had the highest percentage of cases (19.8 and 18.2). There were no consistent differences with respect to sex.

Rubella increased by 16 cases or 7.5 per cent from the first three months of 1974. Comparing cases and incidence rates to the five-year means and rates it was found that the caseload is now 75.8 per cent lower and the incidence rate 77.0 per cent lower. Calgary had 41.8 per cent of the rubella cases giving it the largest caseload. The 5 - 9 year age group clearly had the highest percentage (44.0) of cases. The combined percentage of the bordering age groups yield 32.6 per cent of the total cases. Again no sex trend was observed.

TABLE 1 REPORTED CASES OF THE MORE FREQUENT NOTIFIABLE DISEASES (EXCLUDING VENEREAL DISEASES) BY CITY, HEALTH UNIT OR OTHER JURISDICTION, ALBERTA, APRIL - JUNE 1974

	Salmonellosis		Bacil.	Staph.	Diarr-		Meningo-	Strept		Aseptic Meningitis			Infect.	Serum		
	Food as vehicle	Food not mentioned	Dysen- tery	Food Poisoning	hoea of Newborn	Diph- theria	coccal Infect.	Throat Scarlet F.	Per- tussis	Cox sackie	ECHO	Not Spec.	Hepat- itis	Hepat- itis	Measles	Rubella
Cities																
Edmonton	-	15	3	-	-	-	-	80	-	-	-	-	68	1	97	41
Calgary	-	19	14	-	-	-	2	40	3	-	-	-	56	10	310	95
Grande Prairie	-	-	-	-	-	-	-	6	-	-	-	-	1	-	-	-
Lethbridge	-	3	-	-	-	-	-	5	-	-	-	-	12	1	9	2
Medicine Hat	-	-	-	-	-	-	-	80	4	-	-	-	3	-	2	4
Red Deer	-	-	-	-	-	-	-	-	1	-	-	-	2	-	10	4
Health Units																
Alberta East Central	-	1	-	-	-	-	-	2	-	-	-	-	-	-	63	16
Athabasca	-	1	7	-	-	-	-	61	-	-	-	-	8	-	38	7
Banff National Park	-	-	-	-	-	-	-	-	-	-	-	-	2	-	3	-
Barons Eureka	1	-	-	-	-	-	-	133	-	-	-	-	3	-	4	14
Big Country	-	4	1	1	-	-	-	11	-	-	-	-	-	-	2	-
Chief Mountain	-	-	-	-	-	-	-	8	-	-	-	-	23	-	-	-
Chinook	-	6	-	-	-	-	-	55	-	-	-	-	12	-	-	2
County of Warner	-	1	1	-	-	-	-	2	-	-	-	-	-	-	6	1
Drumheller	-	1	1	-	-	-	-	1	-	-	-	-	-	-	-	-
Edson	-	2	7	-	-	-	-	36	-	-	-	-	3	-	2	-
Foothills	-	1	-	-	-	-	-	6	-	-	-	-	-	-	55	26
Grande Prairie	-	-	3	-	-	2	-	17	-	-	-	-	1	-	-	-
Jasper National Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	-
Leduc - Strathcona	5	-	-	-	-	-	-	24	1	-	-	-	3	-	23	1
Medicine Hat	-	7	1	-	-	-	-	42	-	-	-	-	2	1	5	1
Minburn - Vermilion	-	-	-	-	-	-	-	54	-	-	-	-	1	-	8	-
Mount View	-	-	-	-	-	-	-	6	-	-	-	-	-	-	6	1
North Eastern Alberta	-	3	1	-	-	1	1	9	-	-	-	-	3	-	4	1
Peace River	1	-	18	-	-	-	-	7	-	-	-	-	6	-	70	1
Red Deer	-	-	-	-	-	-	-	-	-	-	-	-	4	-	92	2
Stony Plain - Lac Ste. Anne	-	-	2	-	-	-	-	57	-	-	-	-	4	-	9	-
Sturgeon	-	4	1	-	-	-	-	63	-	-	-	-	-	-	13	-
Vegreville	-	-	-	-	-	-	-	73	-	-	-	-	2	-	6	3
Wetoka	-	-	-	-	-	-	-	4	-	-	-	-	3	-	3	1
Other Jurisdictions																
Canadian Forces	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Indian Reservations	-	3	20	-	-	3	4	50	-	-	-	1	18	-	38	2
Northern Alberta Health Services	-	-	5	-	-	-	-	16	-	-	-	-	6	-	26	2
Other Municipalities	-	-	-	-	-	-	-	1	-	-	-	-	1	-	-	-
Total	7	71	85	1	-	6	7	949	9	-	-	1	247	13	906	227

TABLE 2 REPORTED CASES OF NOTIFIABLE DISEASES BY SEX AND AGE, ALBERTA, APRIL - JUNE 1974

Disease	Under 1		1 - 4		5 - 9		10 - 14		15 - 19		20 - 24		25 - 29		30 - 39		40 - 59		60+		Age not known		Total	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Intestinal Infections																								
Typhoid fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Paratyphoid fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other salmonella infections																								
(a) with food as a vehicle	1	-	-	-	1	3	-	-	-	1	-	-	-	-	-	-	-	1	-	-	-	-	2	5
(b) without mention of food as vehicle	1	10	6	7	7	1	3	2	1	3	-	3	2	-	4	3	3	7	5	3	-	-	32	39
Bacillary dysentery	5	7	25	24	3	5	3	1	1	1	-	-	-	3	1	2	-	2	2	-	-	-	40	45
Staphylococcal food poisoning	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	1
Botulism	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Diarrhoea of the newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Bacterial Diseases																								
Diphtheria	-	2	-	-	1	2	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	4
Meningococcal infections	-	-	-	-	-	1	1	1	-	1	1	-	-	-	-	-	-	2	-	-	-	-	2	5
Streptococcal sore throat and scarlet fever	13	7	95	62	142	141	76	88	52	43	29	37	19	32	23	22	22	26	9	11	-	-	480	469
Pertussis (Whooping cough)	-	1	2	2	2	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	5	4
Virus Diseases of Central Nervous System																								
Aseptic meningitis due to enteroviruses																								
(a) Coxsackie virus	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
(b) ECHO virus	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
(c) Not specified	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	1
Western equine encephalitis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Virus Diseases																								
Infectious hepatitis	1	-	5	2	22	16	14	19	18	28	22	23	17	8	10	11	15	10	1	5	-	-	125	122
Serum hepatitis	-	-	-	-	-	-	1	-	1	2	3	3	1	-	2	-	-	-	-	-	-	-	8	5
Measles	23	35	126	121	159	180	97	112	27	20	1	1	-	2	1	-	-	1	-	-	-	-	434	472
Rubella (German measles)	9	11	19	14	51	49	20	21	9	8	2	4	1	4	2	3	-	-	-	-	-	-	113	114

TABLE 3 REPORTED CASES OF VENEREAL DISEASES BY SEX AND AGE, ALBERTA, APRIL - JUNE 1974

Disease	Under 1		1 - 4		5 - 9		10 - 14		15 - 19		20 - 24		25 - 29		30 - 39		40 - 59		60+		Age not known		Total	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Gonorrhoea																								
Genito-urinary	-	-	-	-	-	4	-	5	178	219	392	234	298	93	263	58	124	20	4	1	16	6	1275	640
Gonoccoal infection of eye	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Syphilis																								
Congenital	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	1	-
Acquired																								
(a) Early symptomatic																								
- Primary	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	2	-	1	-	-	-	4	-
- Secondary	-	-	-	-	-	-	-	-	-	-	1	-	2	-	1	-	2	1	-	-	-	-	6	1
- Other and unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
(b) Latent																								
- Early	-	-	-	-	-	-	-	-	-	1	-	-	2	-	1	-	3	1	-	-	-	-	6	2
- Late	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1	3	1	2	3	-	-	6	5
- Unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
(c) Late																								
- Cardiovascular	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
- Central nervous system	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	1
- Other forms with symptoms	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
- Other and unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Chancroid	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Lymphogranuloma vanereum	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Granuloma inguinale	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

TABLE 4 COMPARISON OF THE REPORTED CASES OF NOTIFIABLE DISEASES AND INCIDENCE RATES, ALBERTA, APRIL - JUNE 1974, WITH AVERAGE CASES AND RATES FOR THE CORRESPONDING QUARTER 1969 - 1973*

Disease	April - June 1974		Average for Second Quarter 1969 - 73	
	Cases	Incidence Rate per 100,000	Cases	Incidence Rate per 100,000
Intestinal Infections				
Typhoid fever	-	-	0.8	0.0
Paratyphoid fever	-	-	-	-
Other Salmonella infections				
(a) with food as a vehicle	7	0.4	30.2	1.9
(b) without mention of food as vehicle	71	4.2	96.6	6.0
Bacillary dysentery	85	5.0	66.4	4.1
Staphylococcal food poisoning	1	0.1	15.4	0.9
Botulism	-	-	-	-
Diarrhoea of the newborn	-	-	1.8	0.1
Other Bacterial Diseases				
Diphtheria	6	0.4	7.8	0.5
Meningococcal infections	7	0.4	4.4	0.3
Streptococcal sore throat and scarlet fever	949	55.5	465.8	28.7
Pertussis (Whooping cough)	9	0.5	18.6	1.1
Virus Diseases of Central Nervous System				
Aseptic meningitis due to enteroviruses				
(a) Coxsackie virus	-	-	-	-
(b) ECHO virus	-	-	-	-
(c) Not specified	1	0.1	1.8	0.1
Western Equine encephalitis	-	-	-	-
Other Virus Diseases				
Infectious hepatitis	247	14.5	289.4	17.8
Serum hepatitis	13	0.8	11.4	0.7
Measles	906	53.0	541.4	33.4
Rubella (German measles)	227	13.3	937.6	57.8

*Population figures for incidence rates come from Statistics Canada's quarterly estimates - catalogue 91-001 for April 1974.

TABLE 5 COMPARISON OF THE REPORTED CASES OF VENEREAL DISEASES AND INCIDENCE RATES BY SEX, ALBERTA, APRIL - JUNE 1973 WITH AVERAGE CASES AND RATES FOR THE CORRESPONDING QUARTER 1969 - 1973*

	April - June 1974				Average for Second Quarter 1969 - 1973			
	Cases		Incidence Rate per 100,000		Cases		Incidence Rate per 100,000	
	M	F	M	F	M	F	M	F
Gonorrhoea								
Genito-urinary	1275	640	146.2	76.5	843.8	355.2	101.9	44.7
Gonococcal infection of eye	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-
Syphilis								
Congenital	1	-	0.1	-	0.6	0.6	0.1	0.1
Acquired	-	-	-	-	-	-	-	-
(a) Early symptomatic								
- Primary	4	-	0.5	-	4.6	0.4	0.6	0.1
- Secondary	6	1	0.7	0.1	4.2	3.6	0.5	0.5
- Other and unspecified	-	-	-	-	0.4	0.6	0.0	0.1
(b) Latent								
- Early	6	2	0.7	0.2	3.6	2.0	0.4	0.3
- Late	6	5	0.7	0.6	2.8	3.8	0.3	0.5
- Unspecified	-	-	-	-	0.4	0.6	0.0	0.1
(c) Late								
- Cardiovascular	-	-	-	-	-	-	-	-
- Central nervous system	-	1	-	0.1	0.2	-	0.0	-
- Other forms with symptoms	-	-	-	-	-	-	-	-
- Other and unspecified	-	-	-	-	0.2	0.2	0.0	0.0
Chancroid	-	-	-	-	-	-	-	-
Lymphogranuloma venereum	-	-	-	-	-	-	-	-
Granuloma inguinale	-	-	-	-	-	-	-	-

*Population figures for incidence rates come from Statistics Canada's quarterly estimates - catalogue 91-001 for April 1974. The 1971 sex ratio is used to calculate male/female populations.

GLOSSARY

Boarding Home - a foster home in which the foster parents receive monetary compensation from the department to cover boarding expenses, clothing, etc, for the ward.

Caseload - the number of households, or units, assisted; these units consisting of one or more persons. Caseload is often used to refer to the collective heads of these units.

Child Welfare Act - a provincial statute assented to in April, 1970. This Act gives the Director of Child Welfare or designated child welfare workers the authority to intervene and take action on behalf of children thought to be neglected as well as responsibility for children alleged to be juvenile delinquents.

Diastolic blood pressure - the minimum arterial pressure, related to heart relaxation.

Free Home - a foster home in which the foster parents have chosen to receive no monetary compensation from the department for the care of the ward.

Guardian Social Allowance (an extension of the social allowance program) - an allowance for basic necessities provided by the department, in the absence of the parent(s), to a person who in the opinion of the director is properly caring for the child.

Hypertension - systemic condition accompanying high blood pressure.

Independent Placement - a situation where an older teenage ward is granted independent status by the Director of Child Welfare to live on his own.

Manometer - an instrument for measuring blood pressure.

Municipal Caseload - a municipality is responsible for assisting an employable person who is a resident of the municipality and
(1) was a resident of the municipality during the twelve months immediately preceding his application, and
(2) did not, during any part of these twelve months, receive material aid from the province or any other municipality.
The municipality is reimbursed 90 per cent by the province for expenditures incurred.

Non-Ward (now called "custody by agreement") - is a child (under the age of 18) whose parents have entered into an agreement with the Director of Child Welfare for the temporary care of the child; the parents retain guardianship rights. Situations which result in custody by agreement, usually involve circumstances such as illness of the parents, or the child, which make care of the child beyond the parents capabilities.

Normotensive - characterized by a normal degree of blood pressure.

Permanent Ward - a child (under the age of 18) whose ties with his natural parents have been completely severed and whose sole custodian and guardian is the Director of Child Welfare. Permanent wardship expires at age 18; but until that time, such children are adoptable.

Reasons for Assistance - the social allowance program is available to those persons who lack the resources or income sufficient to meet their needs and those of their dependents. Eligibility for assistance is defined within the following categories; for each application, the social worker assigns

a reason for assistance on the following rank order basis. That is, applicants are assigned to the first category of reason for assistance that applied to them, proceeding through the list of reasons in their specified order.

Age (Person 60 or over) - A person may be considered eligible for assistance under this reason if 60 years of age or older. Prior to November 1971, women between 55 and 60 years of age were also eligible for Social Allowance by reason of age alone.

Person with Dependent Child(ren) - This reason is applicable to the single parent family where the parent actually has custody of or is personally caring for a dependent child.

Physical Ill Health/Disability - This reason is applicable to a person with a physical disability, impairment, or illness, regardless of expected duration, which prevents rendering services for wages sufficient to meet the person's needs and those of dependents.

Mental Ill Health - This reason is applicable to persons having an obvious mental illness or a medical certificate confirming such mental illness, regardless of the expected duration.

Mental Retardation - This reason is applicable to persons who are mentally retarded. A medical certificate or assessment is required if the disability is not readily recognizable.

Employable - This reason is applicable to persons who are unemployed and seeking employment or whose employability may be under assessment, as well as persons employed full- or part-time with insufficient income. This reason also applies to persons temporarily unavailable for work because of schooling, pregnancy, or in jail for less than 90 days.

Unsuitable for Employment - This reason is applicable to cases which have been assessed as socially, psychologically, or otherwise unsuited for employment. Such cases would be transferred to other reasons for assistance after the assessment period.

Guardian Social Allowance - This is an extension of the Social Allowance program designed to assist persons acting as guardians and providing care to children placed in their homes by parents unable or unwilling to provide such care.

Recipients - In contrast to the term "caseload", this term refers to the unit heads plus their dependents. The number of recipients on assistance is approximately two or three times as great as the caseload.

Systolic blood pressure - maximum blood pressure in circulation, related to heart contraction.

Temporary Ward - children (under the age of 18) who are in custody of the Director of Child Welfare for a temporary period. At the end of this specified period, the temporary wardship is reviewed by the Court. Three possible outcomes of this review are:
(a) the wardship may be allowed to lapse;
(b) the wardship may be renewed for another specified period; or
(c) the Court may rule to request permanent wardship from a higher court.

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